IRI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS DEC 19 1960

6030 6030 -60-045889

STATE FILE NUMBER

NDED

Registration District No. 149 Primary Registration District No. 002 Registrar's No.

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Kansas City
Length of stay in 1b: 70 yrs
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Northeast Restorium
Inside Limits: Yes ☐ No ☐
3240 Norledge

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY: Jackson
c. CITY OR TOWN: Kansas City
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 3240 Norledge
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Anna Middle: Last: Anderson
4. DATE OF DEATH: Month: Nov. Day: 30 Year: 1960
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☐: Never Married
8. DATE OF BIRTH: July 19, 1876
9. AGE (last birthday): 83 84
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HR: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Nurse
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Sweden
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Carl Anderson
13b. MOTHER'S MAIDEN NAME: Christine Nordenberg
14. NAME OF HUSBAND OR WIFE: none
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT Address: Emma Olson 2122 Minnie

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral artery Thrombosis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Cerebral artery Arteriosclerosis
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 24 hr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE: Kansas City Jackson Mo

21. I attended the deceased from Jan 1960 to Nov 30/1960 and last saw her alive on Nov. 28/1960.
Death occurred at 2:05 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): K. L. Shireman MD
22b. ADDRESS: 4606 St John KCMo
22c. DATE SIGNED: 12-3-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE: 12-2-60
23c. NAME OF CEMETERY OR CREMATORY: D. W. Newcomers Sons
23d. LOCATION (City, town, or county) (State): Kansas City, Missouri

24. FUNERAL DIRECTOR ADDRESS: Stine & McClure, Kansas City, Mo.
25. DATE RECD. BY LOCAL REG.: 12-2-60
26. REGISTRAR'S SIGNATURE: H. L. Dwyer

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF K. L. Shireman MEDICAL CERTIFICATION DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed b

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 463

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.